WAR TRAUMA IN VETERANS AND THEIR FAMILIES

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WAR TRAUMA IN VETERANS AND THEIR FAMILIES

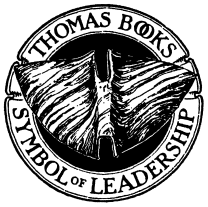
Diagnosis and Management of PTSD, TBI and Comorbidities of Combat Trauma

From Pharmacotherapy to a 12-Step Self-Help Program for Combat Veterans

Edited by

JAMSHID A. MARVASTI, M.D.

(With 17 Other Contributors)



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This book is dedicated to those brave veterans who returned from combat and disclosed the whole truth about the human cost of war and to those warriors who broke the silence of their souls and reported the brutality and inhumanity of their combat experiences.

"In the end, we will remember not the words of our enemies, but the silence of our friends."

Martin Luther King, Jr.

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PREFACE

Our mission in writing this book is to look beyond the politics of war in order to explore the extent of the ongoing and long-term human cost of war and military occupation. This book addresses the suffering of our troops and their families and our responsibility as a society, first to acknowledge and diagnose this suffering, and then to care for those who are affected by it. While it is not intended to take a moralistic or philosophical stance, the editor feels it is important to demonstrate the scale of human agony and loss inherent to war.

We Americans seem to be divided in our response to the present-day military conflicts in the Middle East and North Africa. On one extreme are those who are wholeheartedly supportive of the war and U.S. military invasions abroad. This group believes in America's inherent "goodness" and holds fast to American exceptionalism, arguing that military intervention is beneficial for the liberation and transformation of the world. On the other end of this spectrum are those who are considered peace oriented and who often see the long wars in the Middle East as based more on profit than principle. Some have accused the government and mainstream media of collaborating to sell the concept of war to an unwitting nation.

The largest segment of our population remains the group whose viewpoints lie somewhere in the middle of these two poles, often those who have ambiguous feelings surrounding the wars and U.S. involvement overseas. Some may be unaware of the long-term impact of war on our troops, their families, and society at large. Others may be openly against violence and aggression, but unwilling to challenge the status quo or even unsure of how to initiate change.

Our warriors are an extension of our society, and, therefore, they fall into the same three categories. Some remain steadfastly devoted to the military and the government's interests in war. Others may become conscientious objectors or advocates for peace, perhaps shifting their views of what it means to be "patriotic." Still others are conflicted in their feelings about war, and especially in the roles they may have played in Iraq or Afghanistan.

Scientific research reveals that multiple deployments and our troops' 24/7 involvement in combat where there is no clear front-line is causing serious emotional disorder and physical exhaustion, which contributes to war trauma and combat stress injury. This editor suggests that one way to decrease the suffering of our veterans is ***to reinstate the draft***, even if that means "political suicide" for any policymaker who advocates for such a change. Furthermore, it is unethical and immoral when those who created the war do not send their children, grandchildren, nephews and nieces to fight in it. If war is indeed patriotic and necessary for the survival of our country, then citizens from all socioeconomic classes must take the risk of losing lives, limbs, and developing combat trauma and PTSD. We must all bear the burden of war equally.

Some Americans feel that the current wars are being fought by America's poor and not by the children of millionaires/billionaires and other VIPs. Under conditions of a draft, perhaps more of our leaders would hesitate before supporting a protracted war. Others feel that the draft is not a solution, because even with a draft in place, those in power or with special influence are able to find a way to escape their obligations, as evidenced during and after the Vietnam War.

The U.S. media has provided Americans with vast amounts of information about the basics of the Iraq and Afghanistan wars. Terms such as WMD and IED have become part of daily discourse. We are aware that our servicemen and servicewomen face grave physical danger while patrolling war zones amid 130-degree temperatures while carrying 120-pound loads on their backs. We may, however, be less aware of the psychological strain felt by these men and women as they face multiple deployments in combat zones where civilian casualties and the deaths of comrades are common occurrences. The editor applies a general label to the resultant crisis for combat veterans as psychologically *battered soldier syndrome.*

This editor also sides with those who advocate ***giving the Purple Heart to veterans with war trauma***. Combat veterans who commit suicide as a result of their experiences are also victims of war and deserve to receive the Purple Heart, just as those who are killed on the battlefield. When a wounded warrior returns home and becomes home*less*, it is a tragedy for the nation and a shame for the government. In this sense, does our society present these military personnel with a "broken heart," rather than a Purple Heart?

The following poem, written by a WWII veteran, illustrates some of the limitations of rehabilitation from war trauma in a metaphoric way, confirming General Sherman's statement, "War is hell." (Source: Lee, K. A., Vaillant, G., Torrey, W., & Elder, G. 1995, April 4, A 50-year prospective study of the psychological sequelae of World War II combat. *American Journal of Psychiatry, 152*, 516–522.

Wheat fell headless in the field
Till Death did reap enough.
We seek to bury the revealed
No earth is deep enough.
You cannot wash the stain from minds
No one can weep enough.
Nor shut the past behind the blinds
No night has sleep enough.

DESCRIPTION OF THE BOOK

This book is divided into two sections. The first, "Clinical Issues of War Trauma," contains chapters on signs and symptoms, diagnosis, and pharmacotherapy of war trauma. The second section, "Witnesses to War," is comprised of four first-hand accounts of experiences in combat zones, during and after conflict.

The chapters of this book were written by professionals from different disciplines and with different ideologies. Some have had first-hand involvement in combat, from the Vietnam War to the wars in Iraq and Afghanistan. A chapter by a Ph.D. psychologist describes his experience as a bomber pilot during WWII; he still suffers from PTSD. Other contributors include a young lieutenant and medical officer deployed to Afghanistan; a professor of social work who is the daughter, sister, and wife of a veteran; and a therapist/lawyer who is a retired major of U.S. Army Reserves and was assigned to peacekeeping duties in Bosnia and Haiti, in addition to serving several months in the Iraq War.

The editor included his 12-Step Self-Help Principles for Combat Veterans with PTSD in the Appendix to the book. A Glossary by a physician follows the Appendix for the convenience of readers.

PART I: CLINICAL ISSUES OF WAR TRAUMA

Chapter 1
Impact of War and Combat on Veterans

In this chapter, Dr. Marvasti, a trauma specialist and Dr. Fuchsman, a Vietnam veteran and university faculty member, discuss the negative psychological impact of war on the warrior. They explain that war may have long-lasting effects and emphasize the stages of emotional reaction to com-

bat. In summation, Dr. Fuchsman, says that, just as we see in cigarette packaging, there should be a warning in military advertisements: "The military can be hazardous to your health."

Also included is an exploration of the impact of participation or exposure to atrocities and the killing of enemy combatants, plus adverse impact on self-image and core beliefs of soldiers. Postcombat changes in thinking patterns and content and emotions such as grief and guilt are described.

Chapter 2
Blast-Wave Injuries and TBI: Epidemiology, Pathophysiology, and Symptomatology

In this chapter, two physicians (J. Marvasti and A. Alim-Marvasti) explore the signs and symptoms and pathophysiology of combat-related TBI. They explain that TBI has psychological symptoms, (e.g. anxiety, depression, mood disorder, sluggishness, fatigue, etc.), nonpsychological symptoms, (e.g. headache, nausea, ataxia, tinnitus, dizziness, blurred vision, slurred speech, etc.), and mixed-category symptoms (e.g. amnesia and impaired attention/concentration capacity).

These two physicians advise that any soldiers with mild TBI should not be placed in combat situations where the risk of secondary trauma increases.

Chapter 3
PTSD in Veterans: Signs and Symptoms

In this chapter, Dr. Marvasti and Dr. Anwar explore the symptomatology of PTSD and suggests that although some soldiers should be clinically diagnosed with PTSD, one or two of the symptoms required for an official DSM-IV diagnosis may be absent. There may be a need for new, less-limited criteria for the diagnosis of PTSD.

Every veteran with war trauma presents with unique symptoms in an individual way according to his or her psychology and biology. Leo Tolstoy is quoted, "All happy families resemble one another, each unhappy family is unhappy in its own way."

Chapter 4
Spiritual Distress as a Component of PTSD: The Need for Spiritual Healing

Mary Paquette Ph.D., R.N., discusses spiritual and psychological distress as an aspect of war trauma. She points out that although DSM-IV-TR does not recognize spiritual distress as a PTSD symptom, treatment should nev-

ertheless address ways of relieving it. The military has trained soldiers in how to kill. This training does not prevent the trauma involved in killing, however, which has moral and ethical ramifications.

Chapter 5
Prozac Army:
Medicated Military in Combat, a Controversial Subject

Dr. Marvasti explains his review of clinical literature in regard to (a) the number of veterans on medication (which is excessive, in his opinion) and (b) the efficacy of medication versus the setbacks of side effects. He describes "a medicated army" whose population is divided into two categories; those who need medication to fight and remain hypervigilant and those who need it to reduce mental anguish and achieve a feeling of normalcy. Never in the history of war has such a large quantity of medication been prescribed to its combatants. Marvasti expresses his concern for the practice of administering medication and sending traumatized soldiers to combat, which is not a cure but merely postpones the effects of war trauma. The side-effects of medications may have caused mission failure, suicide, homicide, and violence among veterans of war.

Ultimately, he writes, the best treatment for war trauma is prevention. If PTSD, depression, and suicide are caused by multiple deployments, exhaustion, witnessing of civilian casualties, and exposure to atrocity, then the only way to truly avoid war trauma is to minimize these circumstances.

Chapter 6
Pharmacotherapy for PTSD: Antidepressant Medications

In this chapter, the efficacy, indications, and side effects of antidepressant medications are explored in regard to war trauma and PTSD. The use of antidepressant medications in various classes is discussed, including SSRIs, SNRIs, TCAs, and MAOIs.

Dr. Marvasti refers to literature that indicates that military personnel who are engaged in special high-risk duties (such as aviation and handling of nuclear weapons) are restricted from taking some of these medications while performing their jobs.

Chapter 7
Mood Stabilizers and Antiadrenergics

In this chapter, Dr. Marvasti explores current research on use of mood stabilizers such as divalproex, topiramate, lamotrigine, and so on, and antia-

drenergics (alpha- and beta-blockers). These medications are being used on veterans with war trauma for alleviation of some of the symptoms, including mood swings, explosiveness, violence, and sleep disorder. He discusses combat considerations and explains that mood stabilizers and antiseizure medications may not be appropriate for combat veterans, since some require regular monitoring of blood levels.

Chapter 8
Pharmacotherapy for PTSD: Tranquilizers, Hypnotics, and Neuroleptic Medications

Here, Dr. Marvasti discusses the efficacy, indication, and side effects of tranquilizers (e.g. benzodiazepines), hypnotics (e.g., zolpidem), and neuroleptic antipsychotic medications. Because benzodiazepines may lead to dependency and addiction and also have side effects including amnesia, impaired cognitive/motor function, impaired judgment, drowsiness, ataxia, and rebound anxiety, they are not recommended for any veteran who is in a combat situation. Nonbenzodiazepine sedative or hypnotic medications for insomnia are explored, and their mechanism of action is discussed. These medications include trazodone, prazosin, and doxepin. The author also explains that some classes of drugs, such as beta-blockers, SSRI antidepressants, ACE inhibitors, and antipsychotics, may cause nightmares as a side effect.

Chapter 9
Pharmacotherapy for Alcohol Problems as a Comorbidity of PTSD

In this chapter, Dr. Marvasti and Khairul Nual focus on the impact of alcohol on veterans and discuss alcohol disorder as a possible comorbidity of PTSD and war trauma. As research indicates, PTSD-diagnosed soldiers who consume alcohol are more prone to having anxiety, mood disorders, disruptive behavior, and chronic physical illness. Also, medications used in the treatment of alcohol problems are discussed in detail including, disulfiram naltrexone, acamprosate, and topiramate.

Chapter 10
Fighting for Your Life: Clinical Issues in War Trauma Bereavement

The basic function of any system is considered to be survival, and so it is with grief and bereavement. Survival methods are innate as well as learned.

In this chapter, Karen L. Carney and William J. Pilkington explain the steps involved in acquiring survival techniques. Three main styles of grief expression are described. The authors also examine complicated grief and identify ten risk factors. They offer methods for treating this difficult condition.

The case history of one WWII soldier is presented; his job was to place explosives in caves where the enemy was thought to be hiding. As the man grew older, he was conflicted about his role in the war. While serving, he had considered himself a good soldier, yet all along he knew that women and children also hid in the caves and that he was therefore responsible for the deaths of many innocents. The history describes his expectation, as he neared the end of his life, to be punished after his death for his sins.

Chapter 11
Forensic Aspect of Combat Trauma and PTSD: Special Veterans' Court, Malingering, and Criminal Conduct

A forensic psychiatrist (Dr. Podolski) and a trauma specialist (Dr. Marvasti) explore the issue of malingering and symptom exaggeration in PTSD litigation and compensation procedures. They discuss the connection between PTSD in combat veterans and their criminal activities after they have returned from war, including discussion of veterans in the criminal system and the advantages and disadvantages of having a special treatment court for veterans.

This chapter also reviews the statements of defense attorneys representing combat trauma veterans accused of criminal activity at home. They claim that their clients were not criminals before deployment but rather were "programmed there to be killers" by the military and not then "deprogrammed" upon their return home.

Chapter 12
VETERANS' EXPERIENCES OF WAR

In this chapter, Dr. Dripchak reports on the results of the qualitative research project that she undertook in 2010 under the auspices of Southern CT State University in New Haven, CT. The men and women included in this study were living in the northeast part of the United States at the time when they were interviewed and had served in combats from World War II to the present.

Chapter 13
The Battle After The War: Cultural Challenges for Those Coming Home

In this chapter, Claire Chantal Olivier writes about cultural challenges for veterans who return home with combat trauma. She discusses ways in which they are affected by our culture and society and asks such questions as, "Do heroes have nightmares?" Other subjects such as the dilemma of invisibility and difficulties of working with the VA health system are discussed. She also touches on the subject of "warriors for peace," which explains how a number of war veterans become human rights advocates, religious believers, or peace activists.

Chapter 14
The Effect of Parental Deployment on Children in Military Families

Recent research revealed the surprising discovery that rates of PTSD in family members of war veterans were higher than those in the veterans themselves. This reflects the burden placed on not only the spouses of the deployed but also their children, who may interpret deployment as the loss of a parent and experience increased emotional distress as a result. In this chapter, Dr. Nina Dadlez focuses on children's adjustment, by age group, to the deployment of their parents as she reviews the overall impact on military families. She documents increased psychological morbidity and emotional and behavioral problems in children whose parents have been deployed to war.

Chapter 15
Families of Veterans: The Forgotten War Front

Here, Dr. Dripchak refers to the military adage, "If the military had wanted you to have a family, they would have issued you one," as she reviews the ways in which sending military personnel into combat impacts their family members. She discusses the sacrifices family members are required to make for war, even though they did not themselves volunteer for military duty. In general, life in the military is not compatible with family life.

Chapter 16
Veteran's Suicide: Prevalence, Contributing Factors, and Prevention

Amidst the highly publicized spike in veterans' suicides, the effect of combat trauma is being investigated more than ever before in our country's history. In this chapter, Dr. Marvasti, a trauma specialist, and Dr. Fuchsman, a Vietnam veteran, explore the connections between suicide and combat trauma, PTSD, TBI, side effects of medication, and substance abuse. Distinctions are made between several stages and/or categories of suicide, including suicidal ideation, attempt, parasuicidal behavior, and "inviting suicide."

There is also an overview of the ethical conflicts for combat clinicians who must choose between supporting the warrior or supporting the war. For example, should they evacuate a traumatized (suicidal) soldier or make an attempt at rehabilitation on site? One decision may save the soldier but decrease the fighting capacity of the unit. Dr. Marvasti emphasizes that a clinician must remain a clinician at all times, even in a combat zone, and cannot ignore this responsibility in order to conserve the fighting force. That consideration is the duty of the military command and politicians who initiated the war.

Chapter 17
PTSD in Asian Cultures: Can We Learn From How Other Societies Handle Trauma in Natural Disaster?

Drs. Teo and Lerrigo discuss the emerging field of disaster mental health and how it may serve to inform individuals in coping with combat trauma. They do this by looking to the disaster-prone areas of the Asia-Pacific region. They then attempt to correlate these events in ways that make them applicable to the situation of war and combat trauma. Trauma events that are considered "man-made" have been thought to have a different impact on mental health outcomes when compared to natural disasters; however, these authors focus on the numerous similarities between the two.

PART II: WITNESSES TO WAR

Chapter 18
Warrior Values in Modern Times: My Experience in the Iraq War

In this chapter, Robert Caffrey describes some of his experiences in the war in Iraq, particularly how they relate to what he terms "warrior values." These five core ideals, which he feels are the backbone of warrior conduct, are summarized as discernment, restraint, mercy, adaptability, and honor. Caffrey discusses each of these values in terms of concrete examples from his own experiences as a major (now retired) in the U.S. Army Reserves.

Caffrey also makes the distinction between warriors and policy makers and notes that not all policy makers live up to warrior values when they are engaged in the decision making process that affects us all. He calls attention to the difficulty we encounter when our enemies seem to be fighting without regard to these warrior values, quoting Nietzsche, who warned,"If we do what they do, no matter how justified we believe we are, we will ultimately become what they are." Caffrey cautions readers against the psychological perils of engaging in war without a moral code and expresses his belief that to do so is to dishonor the foundation of warriorhood.

Chapter 19
My Experiences as a Medical Operations Officer in Afghanistan

In this chapter, First Lieutenant Seth Mastrocola discusses his experience in the Afghanistan war as a medical operations officer. Mastrocola recounts one of his most difficult experiences, when one of his soldiers committed suicide by placing a live grenade under his own body. He describes the medics' unsuccessful attempt to revive the young man and the lingering question, "Could I have done more?"

Chapter 20
Guided Missiles and Misguided Leaders: Civilians in War Zones as Observed By a Christian Activist

In this chapter Chris Doucot summarizes some of his observations of the suffering of Iraqi civilians, especially children. Doucot has witnessed the horrors of war first hand, having traveled to Iraq, Afghanistan, Palestine, and

Darfur as a Christian peace activist. He quotes Howard Zinn who said, "Every war is a war against children." Doucot shares what he learned from children who have been gravely injured in U.S. missile attacks, as well as the parents of these children. He reminds us that "In a democracy, we bear responsibility for the actions of our government."

Chapter 21
Far From Being a Hero: My Life as a WWII Pilot

This chapter is the personal account of retired psychologist Dr. Sidney Gitlin, who flew a bomber plane during WWII. He admits to having nightmares and other symptoms of PTSD, and describes what his life is like after sixty years of being flooded with "memories and anxiety reactions to past memories of friends and crew."

Dr. Gitlin shares some of his most difficult experiences, such as when he watched a plane blow up upon landing at the home base. He also describes his discomfort at seeing segregated African-American troops and explains his surprise when, at a movie night, the German prisoners "were seated with all of us, and the African-Americans were segregated to the balcony." His sadness is evident in his comment that when WWII ended he wondered why it could not have been stopped sooner.

J.A.M.

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WAR TRAUMA IN VETERANS AND THEIR FAMILIES

Part I

CLINICAL ISSUES OF WAR TRAUMA

Chapter 1

IMPACT OF WAR AND COMBAT ON VETERANS

JAMSHID A. MARVASTI AND KENNETH A. FUCHSMAN

INTRODUCTION

Death and the risk of bodily injury are known entities in regard to the dangers of combat. What is less obvious is the threat that serving as a soldier can pose to one's mental well-being. One of the great paradoxes of human existence is that much of human civilization alternates between cooperation and conflict, diplomacy and combat (Fuchsman, 2008). As historian John Keegan claims, "Warfare reaches into the most secret places of the human heart" (Keegan, 1993). Gwynne Dyer asserts that "War may be an inescapable part of our genetic heritage" (Dyer, 2004). Yet, for all the possible ways that victory in war has helped cultures survive and prosper, it has come with serious emotional and physical consequences for many immersed in its brutalities.

For many of the veterans who make it back from combat, the aftermath of war and military service and the transition from combat to civilian life can also be hazardous. Absent from the military guidelines are some realities that any veteran entering combat should know: (a) combat exposure may cause posttraumatic stress disorder (PTSD); (b) PTSD is a neurobiological and hormonal imbalance in the human being; (c) untreated PTSD almost always gets worse; (d) those experiencing PTSD may resort to self-soothing and self-medicating through alcohol and street drugs; (e) combat PTSD frequently has comorbidities, such as depression, suicidal behavior, interpersonal difficulties, intimacy disorder, and rage reaction.

Young veterans in combat may get to know chaos, evil, and death in an intimate way, often witnessing each of these multiple times (Nash, 2007).